MyChoice Individual Health Coverage

Application

Important Instructions

- Please print in ink or type.
- Completed application must be received by BlueChoice HealthPlan within 30 days of the signature date.
- The application must be signed where indicated.
- Attach a copy of the applicant's Social Security card along with the first month's premium payment. Make all payments payable to BlueChoice HealthPlan.
- Incomplete or ineligible applications will be returned.
- The completed application and check for the first month's premium should be sent to BlueChoice HealthPlan, AX-430, P.O. Box 6170, Columbia, S.C. 29260-6170.

Coverage does not become effective under any circumstances until an application has been approved by BlueChoice HealthPlan. Coverage will begin the first day of the month after the application has been approved.

An independent licensee of the
Blue Cross and Blue Shield Association

BlueChoiceSC.com

For completion by applicant's (child's) parent or legal guardian or applicant if 18 years or older. **Please Print in Ink or Type**

INFORMATION ABOUT THE APPLICANT

1. Last Name First Name Middle Initial
❑ Male
❑ Female

2. Applicant's Date of Birth Mo. Day Yr.

3. Telephone Number:

4. Is the applicant a resident of South Carolina? ❑ Yes ❑ No

Address: _____

_____

City: _____ County: _____ State: _____ ZIP Code: _____

5. Applicant's Social Security Number:

PLAN SELECTION

6. (Check One)
$500 – 80% ❑ $750 – 80% ❑ $1,000 – 80% ❑ $3,250 – 80% ❑
$1,500 – 70% ❑ $2,500 – 70% ❑ $3,000 – 100% HDHP ❑ $5,000 – 100% HDHP ❑

PRIMARY CARE PHYSICIAN SELECTION

7. Please refer to BlueChoice HealthPlan's Physician Directory.

Name of Primary Care Physician: _____ Is the applicant currently a patient of this physician? ❑ Yes ❑ No

BILLING INFORMATION

Premiums are payable monthly.

FOR USE OF BLUECHOICE HEALTHPLAN

Bank Number:

Account Number:

8. Billing Name: _____

Address: _____

_____

City: _____ State: _____ ZIP Code: _____

MONTHLY BANK DRAFT

If you wish to be billed by bank draft, please complete this Authorization Agreement for pre-arranged payments and attach a voided check.

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS

COMPANY NAME: BlueChoice HealthPlan COMPANY ID NUMBER: _____

I authorize BlueChoice HealthPlan to initiate electronic withdrawals from my Checking account below and the Bank named to debit my account for this MyChoice Individual Health Coverage application and coverage.

BANK NAME: _____ BRANCH: _____

CITY: _____ STATE: _____ ZIP: _____

❑ 1st of the month ❑ 15th of the month MY ACCOUNT NO.: _____

This authority is to remain in force until the Bank has received written notification from me of its termination in such time and in such manner as to afford the Bank a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the Bank prior to charging account. If an erroneous debit entry is initiated by BlueChoice HealthPlan to a customer's account, customer shall have the right to have the amount of the entry credited to his/her account by the Bank, if within 15 calendar days following the date on which the Bank sent to customer a statement of account or a written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank a written notice identifying the entry, stating that the entry was in error and requesting the Bank to credit the amount to his/her account.

ACCOUNT HOLDER'S NAME: _____ ACCOUNT HOLDER'S SOCIAL SECURITY NUMBER: _____

DATE: _____ SIGNED: _____

OTHER INSURANCE

9. Does the applicant have other health insurance including Medicare, TRICARE or Medicaid? ❑ Yes ❑ No

9A. If "yes," will this policy replace that health insurance? ❑ Yes ❑ No

9B. If "yes," list Name(s) of Company. Please explain. _____

_____

9C. If "yes," indicate whether BlueChoice HealthPlan may contact the group and request date of cancellation. ❑ Yes ❑ No
We cannot process an individual applicant who remains active on group coverage.

10A. Has the applicant been covered by BlueCross BlueShield of South Carolina or BlueChoice HealthPlan in the past year? ❑ Yes ❑ No
If "yes," under what identification (Social Security) number? _____

10B. Has the applicant been covered by any other group health insurance in the past year? ❑ Yes ❑ No
If "yes," list name of insurance company and employer group. _____

HEALTH INFORMATION	11. Applicant's Height: _____ ' _____ " Current Weight: _____ lbs.	Recent gain or loss of weight? (circle one) Amount: _____ Reason for weight change: _____

12. In the last 10 years, has the applicant ever had a diagnosis of, advice for, indication of, symptoms related to, treatment for, or injury related to any of the following?

NOTE: If any answer to this section is "yes," please indicate the doctor's name and address, treatment dates, results, medications and any other pertinent information in the space below.

	YES	NO		
A.	❑	❑	Heart or circulatory system, including heart murmur or irregular heartbeat	
B.	❑	❑	Lung or respiratory system, including shortness of breath, asthma, hayfever or other allergies	
C.	❑	❑	Genito-urinary system, including kidney stones, urinary tract infection, menstrual disorder, nephritis, or other kidney or bladder disease	
D.	❑	❑	Digestive system, including ulcer, hernia, gastritis or problems of the stomach, intestines, bowels, rectum, appendix, liver or gallbladder	
E.	❑	❑	Muscular or skeletal system, any disease or disorder of the back, spine, bones, joints or muscles, including arthritis, or lupus, muscular dystrophy, loss of limb or fracture (indicate location of any screws, pins, rods or plates).	
F.	❑	❑	The nervous system, including severe headaches, paralysis, seizures, convulsions, epilepsy, fainting, dizziness, mental or emotional disorders, psychiatric care, cerebral palsy, behavior disorders and educational disorders.	
G.	❑	❑	Eye, ear, nose, throat, mouth or teeth	
H.	❑	❑	Any type of cancer, tumor, cyst or other growth, skin disorder, anemia, hemophilia or other glands, blood and blood-forming organs	
I.	❑	❑	Diabetes or elevated blood sugar	
J.	❑	❑	Sugar, blood or albumin in the urine	
K.	❑	❑	Alcohol or drug dependency, overdose, reaction, abuse or counseling by Alcoholics Anonymous or similar organization	
L.	❑	❑	Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex, or ever tested positive for the HIV virus	
M.	❑	❑	Sudden weight loss, night sweats, persistent fever, fatigue, mouth infection or lymph node enlargement	
N.	❑	❑	Any other abnormality, deformity, birth defect, developmental defect, anomaly, disease or disorder	

13. Is applicant pregnant? ❑ Yes ❑ No

14. In the last 10 years, has the applicant seen a doctor, had surgery, been hospitalized, institutionalized or had an injury requiring medical treatment not already disclosed in this application?
❑ Yes ❑ No If "yes," please explain. _____

_____

15. In the last 12 months, has the applicant taken prescription drugs? ❑ Yes ❑ No If "yes," list drug(s) below.

_____

16. In the last 5 years, has the applicant had symptoms of, or trouble with, any physical, mental or emotional condition for which the applicant has not yet seen a doctor or for which treatment has been recommended? ❑ Yes ❑ No
If "yes," please explain. _____

17. List the name and address of applicant's doctor(s).

DOCTOR'S NAME	DOCTOR'S ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

APPLICANT, PARENT OR LEGAL GUARDIAN – READ CAREFULLY BEFORE SIGNING:

I authorize release to BlueChoice HealthPlan of South Carolina, Inc. all past and future medical records of applicant needed to underwrite this application for coverage and to process claims.

I also understand that the coverage I am applying for to cover applicant will not be in effect until this application is accepted by BlueChoice HealthPlan and until the premium plus any policy fee is paid. BlueChoice HealthPlan assigns effective dates only on the first of the month. Further, I understand that I, as contract holder, will receive a contract and identification card for the applicant if this application is approved. If this application is not approved, any premium and policy fee I have paid will be returned to me.

I agree that the information given by me on this application is complete, true and correctly recorded.

I HAVE READ AND UNDERSTOOD EACH AND EVERY PART OF THIS APPLICATION.

Applicant's, Parent's or Guardian's Signature: _____ Date: _____

If a grandparent is applying to cover applicant, please complete Parental Consent below:

Note: Applicants 18 years of age or older must sign their own applications. Applications for individuals under 18 years old must be signed by parent or legal guardian.

Parental or Guardian Consent

This will serve to notify you that the grandparent of my child, _____ , who is under 18 years of age is making application
(name of child, please print)
for MyChoice Individual Health Coverage for my child, with my full knowledge and consent, and I request that you consider my child for such coverage.

Signature: _____ Print Name: _____ Relationship: _____ Date: _____

Agent's Signature: _____ Agent's 6-Digit Code: 219-005

For BlueChoice HealthPlan use only:

Applicant Accepted ❑ Not Accepted ❑ Effective Date: _____

BlueChoice HealthPlan Identification Number: _____ Underwriter's Signature: _____ Date: _____